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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 23, 2010

Tom Whittemore, Administrator
Communicare, Inc #8 Lincoln
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #8 Lincoln, Provider #13G062

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #8 Lincoln, which was conducted on September 17, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or

other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 5, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by October 5, 2010. If a request for informal dispute resolution is received after October 5, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

BARBARA DERN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

BD/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G062	A. BUILDING _____ B. WING _____	09/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #8 LINCOLN	1128 N LINCOLN JEROME, ID 83338

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiency was cited during the annual recertification survey. The survey was conducted by: Barbara Dern, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED OCT 13 2010 FACILITY STANDARDS	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 2 of 8 individuals (Individuals #3 and #5) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur between individuals and negatively impact their health. The findings include: 1. An environmental review was conducted on 9/15/10 from 2:15 - 2:35 p.m. During that time, the following issues were noted: - Individual #3's grooming kit contained an uncovered toothbrush stored with an electric razor and a hairbrush. - Individual #5's grooming kit contained an	W 455	W 455 Corrective Actions: The protective cap for "spin" toothbrushes at this location are easily lost and/or damaged. "Pencil" boxes for the storage of toothbrushes in grooming kits have already been purchased and are now being used. Identifying Others Potentially Affected: All others at this location are potentially affected. System Changes: A new protective storage device system has been implemented. Monitoring: This is an ideal opportunity for one of the individuals who lives in Jerome to learn more about checking for sanitation. As a weekly assignment, this individual will check all grooming kits to make sure storage containers are in place and are being used properly in all	10/05/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tom Cleveland — Admin — 10-5-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 455	Continued From page 1 uncovered toothbrush stored with two hairbrushes. The leadworker, who was present, stated she would correct it and placed the toothbrushes in zip lock bags. The facility failed to ensure Individual #3 and Individual #5's toothbrushes were stored in a sanitary manner.	W 455	grooming kits. A checklist system will be developed so that this individual, under staff supervision, will follow a specific procedure to inspect all grooming kits and report any problems to the Assistant QMRP (house manager) for correction. The AQMRP will monitor this system.	

Bureau of Facility Standards

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MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	MM 769 Please refer to W455	

Bureau of Facility Standards

Tom Wallbaum — Admin — 10-5-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE